Miss Sarah Richards MBChB MD FRCS
Consultant Surgeon

The Consultant Workforce – Job planning

Where are we now?

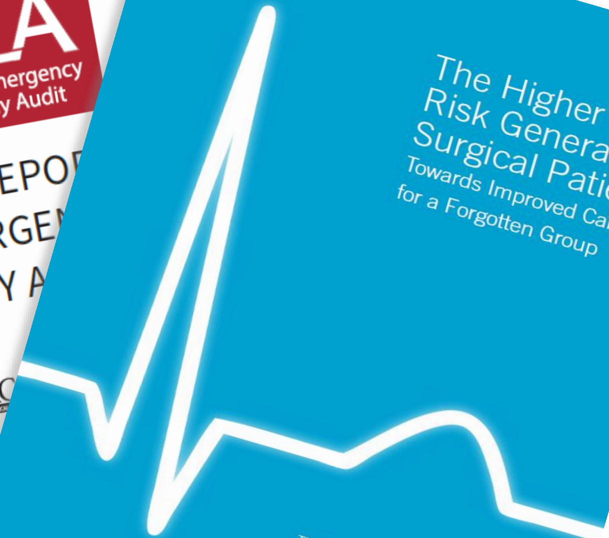
Strong consultant input
Available guidelines
A hot topic!

Emergency Surgery
Standards for unscheduled surgical care

EMERGENCY GENERAL SURGERY
May 2012
Association of Surgeons of Great Britain and Ireland
ISSUES IN PROFESSIONAL PRACTICE
Emergency General Surgery

ASGBI
RCS
Commissioning guide:

NELA
National Emergency Laparotomy Audit



Contributing to Workload

- Focus on elective targets
- 4hour ED target
- European training hours
- Subspecialisation
- Rationalisation of units
- Low priority among managers, clinicians & politicians

- Rise in Patient numbers
  - Ageing & comorbid
- Loss of team structure
- Lack of resources
  - Theatre
  - Diagnostic and interventional radiology
  - Critical care
  - Bed arrangement

Barely manageable workload

Outcomes variable

UK Acute Surgical Unit Survey

- 14 units
- 110 patients per week (range 42-200 patients/week)
- Average reduction LOS by 1.1 days (range 0.9-1.6 days)
- 12% admission avoidance
- Savings £0.45-1.34 million/year
- Many common themes
- 3 units dedicated ambulatory care

Richards S, Anderson I, 2014

Acute Surgical Units- “*Horses for Courses*”

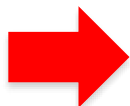
- Hot clinics
- Ambulator
- Urgent ... e lists
- Incr... onsultant input- theatre and fr...
- ...sed frequency of ward rounds
- ...uty Consultant” rather than “on call Consultant”
- Peri-operative physicians
- Emergency General Surgeons

NO TRUST HAS IT PERFECT

Ideal Constituent Components

- Senior led front door service to triage admissions
- Ambulatory care (and virtual ward)
- Acute biliary service
- Emergency laparotomy service and pathway
- Consultant-led assessment of EGS in-patients- twice daily
- Weekend review of complex elective in-patients
- Access to specialised emergency services

What do Trusts Want?



Specialty	2009-2011	2012-2014	Total
Colorectal +/- General	163	150	313
UGI +/- General	111	96	207
EGS/gen	17	36	53

$p=0.008$

L Pearce, E Parkin, S Smith, J Kennedy, A Macdonald
Unpublished data. March 2015.

The job mis-match

- Emergency surgery
  - 50% of bed days
  - Long length of stay
  - 90%+ mortality and 3X greater complication rate
  - Biggest ICU user of all specialties
  - Systems of care relatively unchanged
  - 3 fold variation in outcomes
    - Death, lap chole, CT reporting, consultants in theatre
- AND WE DON’T TRAIN PEOPLE TO LEAD IT?

Emergency General Surgeons

- ?arduous
- ?unpopular
- ?not sustainable
- ?no elective work

Example Trusts - Effective Job planning

Derby

- First "ESAC" established 2012
- Weekdays- consultant surgeon on post-take ward round, consultant surgeon doing emergency operating, consultant surgeon ambulatory care
- Monday- Friday 8am-midnight, followed by week of nights midnight to midday
- Weekend single consultant
- 1:15 overnight and weekend on call (1:8 weekends, 1:8 fortnight block)

Southampton

"When we started I simply created a team to cover the take in a traditional manner but with a small team. It rapidly became apparent that if we were to deliver short length of stay, rapid assessment/turnaround and consultant delivered operating we needed more hours delivering care".

Mr Ian Bailey, Consultant Surgeon, Southampton

Southampton

- 3 consultants in the morning, 2 in the afternoons, 1 evening/overnight
- Traditional weekends but with sub-specialty wards rounds
- 6 dedicated "EGS" consultants each on 12 PAs.

Week One	Monday take week alt days*
Week Two	Elective week
Week Three	Amb Care week
Week Four	Cross cover week
Week Five	Tuesday take week alt days*
Week Six	Elective week

*0800-2100hrs

Oxford

Week One	Hot week, 7 days 0800-1900hrs
Week Two	Cold week, Mon/Tues/Wed 0800-1600hrs
Week Three	Cold week Wed/Thurs/Fri 0800-1600hrs
Week Four	Elective week

- 4 dedicated EGS consultants
- Cold activities- amb care, urgent bookable lists, ward rounds
- 1:18 nights 1900-0800hrs

Bath

- 12 Consultants Surgeons (3 with EGS/ESAC interest)
- Any given day- ESAC Consultant (8am-6pm), Take Consultant (8am-8pm), Colorectal Surgeon of the Week
- Whole weekends, but many surgeons now opt to split due to intensity.
- Annualised ESAC hours

Annualised hours

- Offers robust daily service to cover annual leave/study leave
- Activity calculated over 42 weeks
- 42 x 10 PAs= 420PAs
- On call 52 x 2PAs= 104PAs
- SPA and ward rounds deducted at source
- 168 PA per year for ESAC (502PA/3)
- Remainder elective activity and can be used to cover fallow lists flexibly

Common themes

Everyone working very differently BUT:

•2-3 consultant surgeons out of elective activity on any day

•ALL have elective provision in timetables

•All express need "strong" leadership skills- effective change, business cases, rapid developments

•All feel that the term "on call" is mis-representative !!

- Lead change
- Improve patient care and experience
- Variety of operating
- Elective sub-specialist interest

=Happy & fulfilled surgeon

Where are we now?

- Big changes
- Standards of care and professionally agreed views of future paths
- Subspecialise where we can – but within an overall plan
- Leadership and interest
- Ongoing campaign for resources, protocols, networks
- Sustainable careers
- Need to deliver key standards but how you do it is largely a loco-regional issue